# SECTION 2
# CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 (08-05) claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. MO HealthNet paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
PO Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the MO HealthNet *Providers Manual* available at http://www.dss.mo.gov/mhd/providers/index.htm.

**NOTE:** An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

| Field number and name | | Instructions for completion |
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| 1. | Type of Health Insurance Coverage | Show the type of health insurance coverage applicable to this claim by checking the appropriate box. |
| 1a.* | Insured's I.D. | Enter the patient's eight-digit MO HealthNet ID number (DCN) as shown on the participant's ID card. |
| 2.* | Patient's Name | Enter last name, first name, middle initial in that order as it appears on the ID card. |
| 3. | Patient's Birth Date, Sex | Enter month, day, and year of birth. Mark appropriate box. |
| 4. | Insured's Name | If there is individual or group insurance besides MO HealthNet, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank. |

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| 5. | Patient's Address | Enter address and telephone number if available. |
| 6. | Patient's Relationship to Insured | Mark appropriate box if there is other insurance. |
| 7. | Insured's Address | Enter the primary policyholder's address; enter policy-holder's telephone number, if available. |
| 8. | Patient Status | Not used. |
| 9. | Other Insured's Name | If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. See Note(1) |
| 9a. | Other Insured's Policy or Group Number | Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. See Note(1) |
| 9b. | Other Insured's Date of Birth | Enter the secondary policyholder's date of birth and mark the appropriate box for sex. See Note(1) |
| 9c. | Employer's Name | Enter the secondary policyholder's employer name. See Note(1) |
| 9d. | Insurance Plan Or Program Name | Enter the other insured's insurance plan or program name.<br><br>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. See Note(1) |
| 10a.-10c. | Is Condition Related to: | If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. If the services are not related to an accident, leave blank. |

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| 10d. | Reserved for Local Use | May be used for comments/descriptions. |
| 11. | Insured's Policy or Group Number | Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. See Note(1) |
| 11a. | Insured's Date of Birth, Sex | Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. See Note(1) |
| 11b. | Employer's Name | Enter the primary policyholder's employer name. See Note(1) |
| 11c. | Insurance Plan Name | Enter the primary policyholder's insurance plan name.<br><br>If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan. See Note(1) |
| 11d. | Other Health Plan | Indicate whether the patient has a secondary health insurance plan; if so, complete fields #9-#9d with the secondary insurance information. See Note(1) |
| 12. | Participant's Signature | Leave blank. |
| 13. | Insured's Signature | This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of MO HealthNet. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder. |
| 14. | Date of Current Illness, Injury or Pregnancy | Not required for DME |
| 15. | Date Same/Similar Illness | Leave blank. |

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| 16. | Dates Patient Unable to work | Leave blank. |
| 17. | Name of Referring Physician or Other source | Not required for DME |
| 17a. | Other I.D. | Not required for DME |
| 17b. | NPI | Not required for DME |
| 18. | Hospitalization Dates | Not required for DME |
| 19. | Reserved for Local Use | Providers may use this field for additional remarks or descriptions. |
| 20. | Lab Work Performed Outside Office | Not required for DME |
| 21.* | Diagnosis | Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc. |
| 22. | MO HealthNet Resubmission | For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely. |
| 23. | Prior Authorization Number | Leave blank. |
| 24a.* | Date of Service | Enter the date of service under “from” in month/day/year format, using six-digit format in the unshaded area of the field. All line items must have a "from" date. A "from" and "to" date is required when billing for DME rental. |
| 24b.* | Place of Service | Enter the appropriate place of service code. See Section 15.6 of the DME MO HealthNet Provider Manual for the list of appropriate place of service codes. |
| 24c. | EMG-Emergency | Not required for DME |

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| 24d.* | Procedure Code | Enter the appropriate HCPCS code and applicable modifier(s), if any, corresponding to the service rendered in the unshaded area of the field. (Field 19 may be used for remarks or descriptions.) |
| 24e.* | Diagnosis Pointer | Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field #21 in the unshaded area of the field. |
| 24f.* | Charges | Enter the provider's usual and customary charge for each line item in the unshaded area of the field. This should be the total charge if multiple days or units are shown. |
| 24g.* | Days or Units | Enter the number of days or units of service provided for each detail line in the unshaded area of the field. The system automatically plugs a "1" if the field is left blank. DME rental equipment under the regular DME program, the "from" and "to" dates of service should reflect the month, or portion of the month, in which the item is rented. The quantity must always be a "1". When billing ostomy supplies under A4421, the quantity is always a "1". |
| 24h. | EPSDT/Family Planning | If the service is an EPSDT/HCY screening service or referral, enter "E." |
| 24i. | ID Qualifier | Enter the provider taxonomy qualifier ZZ in the shaded area if the rendering provider is required to report a provider taxonomy code to MO HealthNet.<br>A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers. |
| 24j. | Rendering Provider ID | If the provider taxonomy qualifier was reported in 24i; enter the 10-digit provider taxonomy code in the shaded area.<br>Enter the 10-digit NPI number of the individual rendering the service in the unshaded area. |
| 25. | SS#/Fed. Tax ID | Leave blank. |

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| 26. | Participant Account Number | For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here. |
| 27. | Assignment | Not required on MO HealthNet claims. |
| 28.* | Total Charge | Enter the sum of the line item charges. |
| 29. | Amount Paid | Enter the total amount received by all other insurance resources. Previous MO HealthNet payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field. |
| 30. | Balance Due | Enter the difference between the total charge (field 28) and the insurance amount paid (field 29). |
| 31. | Provider Signature | Leave blank. |
| 32. | Name and Address of Facility | If services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office. |
| 32a. | NPI# | Enter the 10-digit NPI number of the service facility location in 32. |
| 32b. | Other ID# | Enter the Provider Taxonomy qualifier ZZ and Corresponding 10-digit Provider Taxonomy Code for the NPI number reported in field 32a If the provider is required to report a Provider Taxonomy Code to MO HealthNet. Do not Enter a space, hyphen or other separator Between the qualifier and code A provider taxonomy code must be reported If providers have one NPI for multiple legacy MO |
| 33.* | Provider Name/ Number /Address | Affix the billing provider label or write or type the information exactly as it appears on the label. |
| 33a.* | NPI # | Enter NPI number of the billing provider number in 33. |

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| 33b. | Other ID # | Enter the Provider Taxonomy qualifier ZZ and corresponding 10-digit provider taxonomy code for the NPI number reported in field 33a if the provider is required to report a provider taxonomy code to MO HealthNet. Do not enter a space, hyphen or other separator between the qualifier and code.<br><br>A provider taxonomy code must be reported if providers have one NPI for multiple legacy MO HealthNet provider numbers. |

* These fields are mandatory on all CMS-1500 claim form.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, MO HealthNet , employer's name or other information appears in this field, the claim will deny. See Section 5 of the MO HealthNet Provider Manual for further TPL (Third Party Liability) information.

2.7